

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-033097

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 2304

FILED AUG 20 1962

1. PLACE OF BIRTH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		c. CITY OR TOWN Brentwood	
Length of stay in 1b 2 hr 45 min.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL		d. STREET ADDRESS (If outside, give location) 8539 White Ave.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First EDMUND Middle E. Last BRINKMANN			4. DATE OF DEATH Month August Day 7 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1885	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Electrician		10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Francis H. Brinkmann		13b. MOTHER'S MAIDEN NAME Bertha Zoller	
14. NAME OF HUSBAND OR WIFE Angela T. Smith Brinkmann		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Angela T. Brinkmann,		Address above		INTERVAL BETWEEN ONSET AND DEATH	

18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Fracture of skull DUE TO (c) [REDACTED]		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (Also suffered hip injury, at time of fall)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
--	--	--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell	
---	--	---	--

20c. TIME OF INJURY 6:00	Hour 3:45 Month, Day, Year 8/7/62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home	20f. CITY, TOWN, OR LOCATION St. Louis (City)	COUNTY Missouri	STATE
------------------------------------	---	---	---	---	------------------------	-------

21. I attended the deceased from St. Joseph Hospital to [REDACTED] and last saw her alive on [REDACTED] . Death occurred at at 11:25 pm on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE Mildred B. Laemann		(Degree or title) Deputy Coroner		22b. ADDRESS Clayton, Missouri		22c. DATE SIGNED 8/11/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-9-62		23c. NAME OF CEMETERY OR CREMATORY Hiram Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR JAY B. SMITH, MAPLEWOOD, MO.				25. DATE RECD. BY LOCAL REG. 8-9-62		26. REGISTRAR'S SIGNATURE [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1463

24011

3

4 0

5 1

6

7 0

8 2

99047

10 45

11 000

1244-3

13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

H E Burgess

Licensed Embalmer No. _____

4029

P. O. Address _____

Maplewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.